

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
MEDICAL ASSISTANCE ADMINISTRATION  
Olympia, Washington**

**To:** Optometrists  
Opticians  
Managed Care Plans  
CSO Administrators  
Regional Administrators

**Memorandum No: 03-66 MAA**  
**Issued:** September 19, 2003

**For Information Contact:**  
1-800-562-6188

**From:** Douglas Porter, Assistant Secretary  
Medical Assistance Administration (MAA)

**Subject: Discontinued State-Unique Vision Care Procedure & Diagnosis Codes**

**Effective for dates of service on and after October 1, 2003**, the Medical Assistance Administration (MAA) will **discontinue** all state-unique procedure codes and diagnosis codes previously used in the Vision Care Services Program.

### **Coding Changes**

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes and diagnosis codes. In order to comply with HIPAA requirements, MAA is **discontinuing all state-unique procedure codes and diagnosis codes** and will require the use of applicable CPT™ and HCPCS procedure codes, and ICD-9-CM diagnosis codes.

**Continued on the next page...**

## Discontinued State-Unique Procedure Codes

The following state-unique procedure codes will be discontinued for claims with dates of service after September 30, 2003:

Discontinued State-Unique Code	Description
0311M	Operating costs in nursing homes. [Allowed once per day, per provider (not per client and not per facility) <u>when</u> eyeglass fitting or eligible repair services are performed.]
9274M	Materials for eyeglasses repair.
9275M	Fitting fee for therapeutic bandage lenses.
9276M	Fitting fee for contact lenses.
9277M	Fitting of contact lenses for treatment of disease.

## Billing for Vision Care Services Using CPT and HCPCS Codes

Use the following CPT and/or HCPCS codes to bill for vision care services:

Discontinued State-Unique Code	Replacement CPT Code	Modifier	Brief Description
0311M	V2799 <i>Billable by Opticians only.</i>	TT	Miscellaneous vision service [Use to bill for operating costs when services are done in a nursing home. Allowed once per day, per provider (not per client and not per facility) <u>when</u> eyeglass fitting or eligible repair services are performed.]
9274M	92390		Supply of spectacles [Use this for materials for eyeglass repairs only.]
9275M	92070		Fitting of contact lens  <i>New code does not include any follow-up days</i>

**Modifier TT:** Individualized service provided to more than one patient in same setting

Discontinued State-Unique Code	Replacement CPT Code	Modifier	Brief Description
9276M	92310 92311 92312 92313  <i>Billable by Optometrists only.</i>		Contact lens fitting  <i>New code does not include any follow-up days</i>
	92314 92315 92316 92317  <i>Billable by Opticians only</i>		Prescription of contact lens  <i>New code does not include any follow-up days</i>
9277M	This code is discontinued. There is no assigned replacement code for this activity		

## Discontinued State-Unique Diagnosis Code

Effective for claims after September 30, 2003, **state-unique diagnosis code 367.99 is discontinued**. MAA required the use of state-unique diagnosis 367.99 to describe instances when, due to a prescription change of  $\pm 1$  diopter, it is medically necessary to perform an eye exam, a refraction, or to bill for a fitting fee for an adult more often than once every 24-months.

MAA now requires providers to **bill using an Expedited Prior Authorization (EPA) number** when, due to a prescription change of  $\pm 1$  diopter, it is medically necessary to bill more often than once every 24-months for eye exams, refractions, or fitting fees for adults. For more information on creating an EPA number, refer to Section I of the attached replacement pages for MAA's Vision Care Billing Instructions.

Replacement pages are attached for MAA's Vision Care Billing Instructions, dated September 2000, reflecting these HIPAA changes. To view and/or download the entire Vision Care Billing Instructions or this memoranda, go to MAA's website at <http://maa.dshs.wa.gov> (click on the Provider Publications/Fee Schedules link).

Bill MAA your usual and customary charge.

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# Important Contacts

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A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)].

**Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?**

Call the toll-free line:  
(866) 545-0544

**Where do I send my claims?**

Division of Program Support  
PO Box 9248  
Olympia WA 98507-9248

**Where can I find MAA's billing instructions and numbered memoranda?**

Go to MAA's website:  
<http://maa.dshs.wa.gov/RBRVS/rbrvs.htm>

**Where can I get information on electronic billing?**

Go to:  
<http://maa.dshs.wa.gov/ecs>

**Where do I send completed prescriptions and/or purchase orders for sample kits, eyeglass frames, lenses, and contact lenses?**

Airway Optical  
11919 West Sprague Avenue  
PO Box 1959  
Airway Heights, WA 99001-1959  
Customer Service: 1-888-606-7788  
Fax: 1-888-606-7789

**Where do I call or write if I have questions regarding...**

**Policy, payments, denials, or general questions regarding claims processing, Healthy Options?**

Provider Relations Unit  
(800) 562-6188

**Private insurance or third-party liability, other than Healthy Options?**

Division of Client Support  
Coordination of Benefits Section  
(800) 562-6136

**Limitation Extension**

Division of Medical Management  
Quality Fee for Service Section  
Limitation Extension  
PO Box 45506  
Olympia, WA 98504-5506  
Telephone: (360) 725-1583  
Fax: (360) 586-1471

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# Client Eligibility

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## Who is eligible for vision care services?

Clients with one of the following identifiers on their Medical Identification cards are eligible for vision care services:

Medical Identifier	Medical Program
<b>CNP</b>	Categorically Needy Program
<b>CNP – CHIP</b>	Categorically Needy Program – Children’s Health Insurance Program
<b>GA-U - No Out of State Care</b>	General Assistance-Unemployable - No Out of State Care
<b>General Assistance – No Out of State Care</b>	ADATSA
<b>LCP – MNP</b>	Limited Casualty Program - Medically Needy Program

### Limited Coverage:

Clients with the following identifiers on their Medical ID cards are restricted to services associated with an emergency medical condition (payable in a hospital setting only). Office and ambulatory surgical center services are not payable when the clients have the following identifiers on their Medical ID cards.

Medical Identifier	Medical Program
<b>CNP – Emergency Medical Only</b>	Categorically Needy Program – Emergency Medical Only
<b>LCP-MNP Emergency Medical Only</b>	Limited Casualty Program – Medically Needy Program (Emergency Medical Only)
<b>QMB-Medicare Only</b>	Qualified Medicare Beneficiary (Medicare Premiums/Copays Only)

## Are clients enrolled in an MAA managed care plan eligible for vision care services?

Clients with an identifier in the HMO column on their Medical ID cards are enrolled in one of MAA's managed care plans. **Eye exams, refractions, and/or visual fields** must be requested and provided directly through the client's managed care plan. Clients can contact their plans by calling the telephone number listed on their Medical ID card.

**Frames, lenses, and contact lenses** must be ordered from MAA's contractor. These items are covered fee-for-service. (See information on ordering, page J.2.) Eligibility, coverage, and billing guidelines found in this billing instruction apply to clients enrolled in an MAA managed care plan.

Primary Care Case Management (PCCM) clients will have the PCCM identifier in the HMO column on their Medical ID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the HCFA-1500 claim form. (See the *Billing* section for further information.)



**Note: For further information on Healthy Options, see MAA's website:**  
<http://maa.dshs.wa.gov/HealthyOptions>.

# Eye Care Services

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**Eye Examinations and Refractions – billable by Optometrists and Ophthalmologists.**

**Fitting Fees – billable by Opticians/Optometrists/Ophthalmologists.**

## What services are covered and how often?

### Eye examinations, refractions, and fitting fees

<b>MAA covers medically necessary eye examinations, refractions, eyeglasses (frames and lenses), and fitting fees as follows:</b>		
Asymptomatic clients	Adults (21 years or older)	Once every 24 months
Asymptomatic clients	Children (20 years or younger)	Once every 12 months
Clients identified by MAA as developmentally disabled ( <i>MAID card will have an “X” in the DD Client column.</i> )	Adults and Children	Once every 12 months

*(The provider must document the diagnosis and/or treatment in the client’s record to justify the frequency of examinations and other services.)* MAA limits eyeglass reimbursement to specific contract frames and contract lenses. MAA pays a fitting fee for frames, lenses, and contact lenses provided by, or obtained through, the contractor (see Section J: Where and How Do I Order?). If the client has a serviceable frame that meets MAA’s size and style requirements, MAA will pay for a fitting fee.

**Under what circumstances would the above previous limits NOT apply?**

1. **Change in prescription (spherical equivalent of  $\pm 1$  diopter):** The limitations for adults listed on page D.1 do not apply to a change in prescription spherical equivalent of  $\pm 1$  diopter. You must **bill any additional services or supplies using an appropriate Expedited Prior Authorization (EPA) number** from Section I.
2. **Clients in nursing facilities:** MAA reimburses for services provided to clients in a nursing facility. Services must be ordered by the client's attending physician and documented in the facility's client care plan. The need for services must be clearly documented in the facility's client medical record, and the corresponding services provided must be documented in the medical record at the time the services are delivered.
3. **Eye examinations relating to medical conditions:** MAA reimburses for examinations relating to medical conditions (e.g., glaucoma, conjunctivitis, corneal abrasion/laceration, etc.) as often as medically necessary.
4. **Eye exam due to lost or broken glasses**

MAA covers eye exams within two years of the last exam when no medical indication exists and **both** of the following are documented in the client's record:

- The glasses or contacts are broken or lost; and
- The last exam was 18 months ago or longer.



**Note: For billing, see Section I – Authorization.**

5. **Visual field exams (CPT codes 92081, 92082, and 92083):** MAA covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. MAA does not reimburse visual field exams that are done by simple confrontation. Use Medicare criteria for the billing of visual field services for MAA clients. Your records must support medical necessity for the visual field tests.

Documentation in the record must show:

- ✓ The extent of the testing;
- ✓ Why the testing was reasonable and necessary for the client; and
- ✓ The medical basis for the frequency of testing.

## Replacements

MAA covers replacement eyeglasses (lenses/frames) that have been broken or lost as follows:	
Clients 21 years and older	Requires MAA's expedited prior authorization (see Section I)
Clients 20 years and younger	Does not require MAA's prior authorization
Clients identified by MAA as developmentally disabled, regardless of age ( <i>MAID card will have an "X" in the DD Client column.</i> )	Does not require MAA's prior authorization

## Repairs (Upon expiration of the one-year warranty period by contractor) Billable by Ophthalmologists/Optometrists/Opticians)

Eyeglass repair includes replacement of frame front, temple(s), soldering, and/or hinge repair. MAA covers incidental repairs to a client's eyeglass frames when both of the following apply:

- The repair or adjustment is not typically provided to the public at no cost (such as tightening and/or straightening the frame, or replacing a hinge screw); and
- The cost of the repair does not exceed MAA's cost for replacement frames.

Eyeglass repair parts and materials may be ordered from the state contractor or any manufacturer of optical devices and will be paid up to MAA's maximum allowable fee for repair.

## Billing for Supplies Used for Repairs

Please use the following procedure code when billing MAA for an eyeglass repair:

CPT™ Procedure Code	Description
92390	Materials for eyeglass repair (specify materials billed)

**Note:** Use CPT code 92390 for repairs only when materials are being replaced. Materials must be documented with an invoice or like statement from the manufacturer or the contractor showing the client's name. If the needed materials are in stock and a charge is normally made to the public for these materials, the repair fee requirement would be satisfied providing that the use of the specific part is documented in the client's record.

## Additional Options

### Nonallergenic frames

If the client has a medically diagnosed allergy to metal, MAA covers coating the frames to make them non-allergenic.

### Upgrades

MAA **does not** authorize clients to upgrade eyeglass frames and pay only the upgrade costs in order to avoid MAA's contract limitations.

### Back-up eyeglasses

MAA covers back-up eyeglasses when contact lenses are the client's primary visual correction aid (see Contact Lenses section, page G.1) as follows:

Clients 20 years or younger	One pair every two years
Clients 21 years and older	One pair every six years
Clients – Regardless of Age	When MAA agrees in advance to the medical necessity.

## What is not covered?

- ✓ Contact lens for a client who has received MAA-covered eyeglasses within the past 2 years, unless the provider can document the medical necessity to MAA's satisfaction;
- ✓ Disposable contact lens; or
- ✓ Contact lens upgraded at private expense to avoid MAA's contract limitations.

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# Ocular Prosthetics

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**Not payable to Opticians.**

## **When does MAA cover ocular prosthetics?**

MAA covers ocular prosthetics when they are medically necessary and provided by any of the following enrolled/contracted providers:

- An Ophthalmologist;
- An Ocularist; or
- An Optometrist who specializes in orthotics.

## **Billing**

**Procedure Codes:** Refer to MAA's Physician-Related Services Billing Instructions for a complete listing of CPT codes and maximum allowables or go to: <http://maa.dshs.wa.gov>, click on Provider Publications/Fee Schedules.

**HCPCS Procedure Codes:** Please use one of the HCPCS procedure codes listed in the fee schedule when billing for Ocular Prosthesis.

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(Memo #03-66MAA)

Revised October 2003

- H.1 -

**Ocular Prosthetics/  
Cataracts Surgeries**

# Cataract Surgeries

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**This information is for referral purposes only.**

## **When does MAA cover cataract surgery?**

MAA covers cataract surgery when it is medically necessary and the provider clearly documents the need in the client's file.

MAA considers the surgery medically necessary when the client has either of the following:

- Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or
- One or more of the following conditions:
  - ✓ Dislocated or subluxated lens;
  - ✓ Intraocular foreign body;
  - ✓ Ocular trauma;
  - ✓ Phacogenic glaucoma;
  - ✓ Phacogenic uveitis; or
  - ✓ Phacoanaphylactic endophthalmitis.

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# Authorization

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(Ophthalmologists, Optometrists, Opticians)

## What is prior authorization?

Prior authorization is MAA approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization and limitation extensions are forms of prior authorization.**

## What are Limitation Extensions?

Limitation extensions are cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administration Code (WAC).

 **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

**For example:** Eyeglasses are not covered under the Family Planning Only Program.

## How do I request a limitation extension?

There are two ways to request a limitation extension:

- 1) Providers may be able to obtain authorization for these limitation extensions using an expedited prior authorization number. These EPA numbers will be subject to post payment review as in any other authorization process. (See “What is expedited prior authorization,” page I.3.)
- 2) In cases where the client’s situation does not meet the EPA criteria for a limitation extension, but the provider still feels that additional services are medically necessary, the provider must request MAA-approval in writing.

### The request must state the following in writing:

1. The name and PIC number of the client;
2. The provider’s name, provider number and fax number;
3. Additional service(s) requested;
4. Date of last dispense and copy of last two prescriptions;
5. The primary diagnosis code and CPT code or state assigned code; and
6. Client-specific clinical justification for additional services.

### Send your written request for a limitation extension to:

Medical Request Coordinator  
MAA/DMM  
Limitation Extension  
PO Box 45506  
Olympia, WA 98504-5506  
Telephone: (360) 725-1583  
Fax: (360) 586-1471

**ON-LINE CORRECTION**  
**10/22/03**

## What is expedited prior authorization (EPA)?

EPA numbers are designed to eliminate the need for written authorization. MAA establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an EPA number using those codes.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **form a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see pages I.4 and I.5 for codes). Enter the EPA number on the billing form in *field 23*, or in the *Authorization* or *Comments* field when billing electronically.

**Example:** The 9-digit authorization number for an exam for a client who has had an exam 20 months ago but now has lost his or her glasses, would be **870000610**

**870000** = first six digits of all expedited prior authorization numbers;

**610** = last three digits of an EPA number indicating the service and which criteria the case meets

- MAA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.
- The billing provider must document in the client's file how the expedited prior authorization criteria was met, and make this information available to MAA on request.

**Expedited Prior Authorization  
Criteria Coding List on next page** 

## Washington State Expedited Prior Authorization Criteria Coding List

Code	Criteria	Code	Criteria
<b>Visual Exams (Optometrists/Ophthalmologists Only)</b> CPT: 92014-92015		<b>619     <u>Durable Frames</u></b> when <u>one</u> of the following is documented in the client's record: <ol style="list-style-type: none"> <li>1) The client is diagnosed with a seizure disorder that results in frequent falls; <u>or</u></li> <li>2) The client has a medical condition that has resulted in two or more broken eyeglass frames in a 12-month period.</li> </ol>	
<b>610     <u>Eye Exam</u></b> within two (2) years of last exam when no medical indication exists and <u>both</u> of the following are documented in the client's record: <ol style="list-style-type: none"> <li>1) Glasses or contacts are broken or lost; <u>and</u></li> <li>2) Last exam was 18 months ago or longer.</li> </ol>		<b>620     <u>Flexible Frame</u></b> when <u>one</u> of the following is documented in the client's record: <ol style="list-style-type: none"> <li>3) The client is diagnosed with a seizure disorder that results in frequent falls; <u>or</u></li> <li>4) The client has a medical condition that has resulted in two or more broken eyeglass frames in a 12-month period.</li> </ol>	
<b>Dispensing\Fitting Fees For Glasses</b> CPT: 92340-92342		<b>Dispensing\Fitting Fees For Lens Only</b> CPT: 92341, <b>92342</b>	
<b>615     <u>Glasses (both frames and lens)</u></b> within two (2) years of last dispense may be replaced when glasses are broken or lost and <u>all</u> of the following are documented in the client's record: <ol style="list-style-type: none"> <li>1) Copy of current prescription (must not be older than 17 months); <u>and</u></li> <li>2) Date of last dispense; <u>and</u></li> <li>3) Both frames and lens are broken or lost.</li> </ol>		<b>623     <u>Lens Only</u></b> within two (2) years of last dispense when the lens only are lost or broken and <u>all</u> of the following are documented in the client's record: <ol style="list-style-type: none"> <li>1) Copy of current prescription (prescription must not be older than 17 months); <u>and</u></li> <li>2) Date of last dispense; <u>and</u></li> <li>3) Documentation of lens damage or loss.</li> </ol>	
<b>Dispensing\Fitting Fees For Frames Only</b> CPT: 92340		<b>ON-LINE CORRECTION FIXED TYPO 10/22/03</b>	
<b>618     <u>Frames Only</u></b> within two (2) years of last dispense may be replaced when frames only are broken, and all of the following are documented in the client's record: <ol style="list-style-type: none"> <li>1) No longer covered under the manufacturer's one (1) year warranty; <u>and</u></li> <li>2) Copy of current prescription demonstrating the need for prescription eye wear; <u>and</u></li> <li>3) Documentation of frame damage.</li> </ol>			

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Code	Criteria	Code	Criteria
624	<p><b><u>Lens Only</u></b> within two (2) years of last dispense, for refractive changes (provider error is the responsibility of the provider to warranty their work and replace the lens at no charge) when <b><u>all</u></b> of the following are documented in the client's record:</p> <ol style="list-style-type: none"><li>1) Copy of current prescription (prescription must not be older than 17 months); <b><u>and</u></b></li><li>2) Date of last dispense; <b><u>and</u></b></li><li>3) The current exam shows a refractive change of .75 diopters or more; <b><u>and</u></b></li><li>4) The client has headaches, blurred vision, difficulty with school or work and it has been diagnosed by a physician as caused from the inability to see adequately; <b><u>and</u></b></li><li>5) The client does not have a medical condition that is known to cause temporary visual acuity changes (e.g. diabetes, pregnancy).</li></ol> <p><b>Note: In conditions other than pregnancy, if vision has been stable for 3 months and medical condition is stable, lens are allowed when (1)-(4) previously listed are true.</b></p>	<p><b><u>Dispensing/Fitting Fees For Contacts</u></b> <b>Procedure Codes:</b> 92070, 92310-92317</p> <p>627     <b><u>Contacts (client must meet criteria listed in Section G – Contact Lens)</u></b> within one (1) year of last dispense may be replaced when contacts are broken or lost and <b><u>both</u></b> of the following are documented in the client's record:</p> <ol style="list-style-type: none"><li>1) Copy of current prescription (must not be older than 17 months); <b><u>and</u></b></li><li>2) Date of last dispense documented.</li></ol> <p><b><u>Change in Prescription (<math>\pm</math> 1 diopter)</u></b></p> <p>628     <b><u>Eye Examinations/Refractions/Fitting Fees Within the 24 Month Limitation for Adults</u></b> - The 24 month limitation for adult eye exams, refractions, eyeglasses and fitting fees <b>does not apply</b> if the following are documented in the client's record:</p> <ul style="list-style-type: none"><li>• Copy of previous and new refraction reflecting a change (spherical equivalent) of plus or minus 1 diopter AND</li><li>• Copy of new prescription</li></ul>	
625	<p><b><u>High Index Lens</u></b> when <b><u>one</u></b> of the following is documented in the client's record:</p> <ol style="list-style-type: none"><li>1) Spherical correction is greater than, or equal to, <math>\pm</math> 8 diopters; <b><u>or</u></b></li><li>2) Cylinder correction is greater than, or equal, to <math>\pm</math> 3 diopters.</li></ol>		
626	<p><b><u>Executive bifocals and trifocals</u></b> for clients 11 years of age and older, with a diagnosis of accommodative esotropia or strabismus documented in the client's record.</p>		

(CPT codes and descriptions are copyright the American Medical Association.)

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# Fee Schedule

Due to its licensing agreement with the American Medical Associations, MAA publishes only the official, brief CPT procedure code descriptions. To view the entire description, please refer to your current CPT book.

## Payable to Ophthalmologists, Optometrists and Opticians

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/03 NFSFS	
Contact Lens Services			
92070	Fitting of contact lens for treatment of disease (Does not include any follow-up days)	\$39.81	\$23.43
Spectacle Fitting fees, monofocal			
92340	Fitting of spectacles	24.80	24.80
92352	Special spectacles fitting	24.80	24.80
Spectacle Fitting fees, bifocal			
92341	Fitting of spectacles	27.98	27.98
Spectacle Fitting fees, multifocal			
92342	Fitting of spectacles	29.80	29.80
92353	Special spectacles fitting	29.12	29.12
Other			
92354	Special spectacles fitting	204.30	204.30
92370	Repair & adjust spectacles	20.48	10.47
92371	Repair & adjust spectacles	14.56	14.56
92390	Supply of spectacles (Use for materials for eyeglass repair only.)	15.17	15.17
92499	Eye service or procedure	B.R.	B.R.

Fitting fees are not covered by Medicare and may be billed directly to the MAA without attaching a Medicare denial.

NFS = Non-facility Setting; FS = Facility Setting

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(Memo #03-66 MAA)

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Fee Schedule

## Payable to Ophthalmologists and Optometrists Only

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/03	
		NFS	FS
General Ophthalmological Services			
92002	Eye exam, new patient	41.86	28.21
92004	Eye exam, new patient	76.21	54.14
92012	Eye exam established pat	37.99	22.07
92014	Eye exam & treatment	56.65	36.17
Special Ophthalmological Services			
92015	Refraction	43.45	12.29
92018	New eye exam & treatment	82.13	82.13
92019	Eye exam & treatment	43.45	43.45
92020	Special eye evaluation	29.57	12.29
92060	Special eye evaluation	32.99	32.99
92060 – TC	Special eye evaluation	10.24	10.24
92060 – 26	Special eye evaluation	22.52	22.52
92065	Orthoptic/pleoptic training	#	#
92065 – TC	Orthoptic/pleoptic training	#	#
92065 – 26	Orthoptic/pleoptic training	#	#
92081	Visual field examination(s)	28.89	28.89
92081 - TC	Visual field examination(s)	17.06	17.06
92081 - 26	Visual field examination(s)	12.06	12.06
92082	Visual field examination(s)	34.58	34.58
92082 – TC	Visual field examination(s)	20.25	20.25
92082 – 26	Visual field examination(s)	14.56	14.56
92083	Visual field examination(s)	43.23	43.23
92083 – TC	Visual field examination(s)	26.39	26.39
92083 – 26	Visual field examination(s)	16.61	16.61
92100	Serial tonometry exam(s)	37.77	29.80

NFS = Non-facility Setting; FS = Facility Setting

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Fee Schedule

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/03	
		NFS	FS
92120	Tonography & eye evaluation	37.08	26.16
92130	Water provocation tonography	39.59	27.30
92135	Ophthalmic dx imaging	38.67	38.67
92135 – TC	Ophthalmic dx imaging	26.84	26.84
92135 – 26	Ophthalmic dx imaging	11.83	11.83
92136	Ophthalmic biometry	56.65	56.65
92136 – TC	Ophthalmic biometry	38.67	38.67
92136 – 26	Ophthalmic biometry	17.97	17.97
92140	Glaucoma provocative tests	34.13	16.38
<b>Ophthalmoscopy</b>			
92225	Special eye exam, initial	13.88	12.51
92226	Special eye exam, subsequent	12.51	11.15
92230	Eye exam with photos	52.78	18.43
92235	Eye exam with photos	81.45	81.45
92235 – TC	Eye exam with photos	53.92	53.92
92235 - 26	Eye exam with photos	27.30	27.30
92240	Icg angiography	143.10	143.10
92240 – TC	Icg angiography	106.24	106.24
92240 – 26	Icg angiography	36.86	36.86
92250	Eye exam with photos	45.95	45.95
92250 – TC	Eye exam with photos	31.17	31.17
92250 – 26	Eye exam with photos	14.79	14.79
92260	Ophthalmoscopy/dynamometry	10.24	6.83
<b>Other Specialized Services</b>			
92265	Eye muscle evaluation	62.34	62.34
92265 – TC	Eye muscle evaluation	37.08	37.08
92265 – 26	Eye muscle evaluation	25.25	25.25

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Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/03	
		NFS	FS
92270	Electro-oculography	59.61	59.61
92270 – TC	Electro-oculography	32.76	32.76
92270 – 26	Electro-oculography	26.84	26.84
92275	Electroretinography	68.93	68.93
92275 – TC	Electroretinography	35.72	35.72
92275-26	Electroretinography	33.21	33.21
92283	Color vision examination	23.89	23.89
92283 – TC	Color vision examination	18.43	18.43
92283 – 26	Color vision examination	5.69	5.69
92284	Dark adaptation eye exam	58.24	58.24
92284 – TC	Dark adaptation eye exam	50.51	50.51
92284 – 26	Dark adaptation eye exam	7.74	7.74
92285	Eye photography	24.34	24.34
92285 – TC	Eye photography	17.75	17.75
92285 – 26	Eye photography	6.83	6.83
92286	Internal eye photography	81.22	81.22
92286 – TC	Internal eye photography	59.15	59.15
92286 – 26	Internal eye photography	21.84	21.84
92287	Internal eye photography	80.76	25.93
<b>Contact Lens Services</b>			
92310	Contact lens fitting	52.78	37.54
92311	Contact lens fitting	50.96	33.21
92312	Contact lens fitting	54.83	40.72
92313	Contact lens fitting	46.64	27.76

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## Payable to Ophthalmologists and Optometrists Only

HCPCS Code	Description	Maximum Allowable Effective 7/1/03 All Settings
<b>Ocular Prosthesis</b>		
V2623	Prosthetic, eye, plastic, custom	\$862.80
V2624	Polishing/resurfacing of ocular prosthesis	65.09
V2625	Enlargement of ocular prosthesis	395.77
V2626	Reduction of ocular prosthesis	213.33
V2627	Scleral cover shell	1,377.82
V2628	Fabrication and fitting of ocular conformer	325.33
V2630	Anterior chamber intraocular lens	342.42
V2631	Iris, supported intraocular lens	342.42
V2632	Posterior chamber intraocular lens	342.42

## Payable to Opticians Only

Procedure Code/ Modifier	Description	Maximum Allowable Effective 7/1/03 NFSFS	
Contact Lens Services			
92314	Prescription of contact lens	\$37.54	\$21.84
92315	Prescription of contact lens	30.94	14.11
92316	Prescription of contact lens	37.54	22.29
92317	Prescription of contact lens	32.99	13.42
Miscellaneous Vision Services			
V2799 - TT	Miscellaneous vision service <i>Use for operating costs in nursing homes. (Allowed once per visit, per facility, regardless of how many clients are seen, when eyeglass fitting or eligible repair services are performed.)</i>	17.01	17.01

NFS = Non-facility Setting; FS = Facility Setting

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Fee Schedule

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NFS = Non-facility Setting; FS = Facility Setting

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**Fee Schedule**

- |  |  |
|--|--|
| <p><b>11c. <u>Insurance Plan Name or Program Name:</u></b> Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. <i>(Note: This may or may not be associated with a group plan.)</i></p> <p><b>11d. <u>Is There Another Health Benefit Plan?:</u></b> Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i>. If yes, you should have completed <i>fields 9a.-d.</i> If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i>. If <b>11d.</b> is left blank, the claim may be processed and denied in error.</p> <p><b>17. <u>Name of Referring Physician or Other Source:</u></b> When applicable, enter the referring physician or Primary Care Case Manager name.</p> <p><b>17a. <u>ID Number of Referring Physician:</u></b> When applicable, 1) enter the 7-digit MAA-assigned primary physician number; or 2) when the PCCM referred the service, enter his/her 7-digit identification number here. If the client is enrolled in a PCCm plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.</p> | <p><b>19. <u>Reserved For Local Use:</u></b> When applicable, enter indicator <b>B</b> to indicate "Baby on Parent's PIC." Please specify twin A or B, triplet A, B, or C here.</p> <p><b>21. <u>Diagnosis or Nature of Illness or Injury:</u></b> When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.</p> <p><b>22. <u>Medicaid Resubmission:</u></b> When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the <i>Remittance and Status Report</i>.)</p> <p><b>23. <u>Prior Authorization Number:</u></b> When applicable. If the service or equipment you are billed for requires authorization, enter the 9-digit number assigned to you. Only one authorization number is allowed per claim.</p> <p><b>24. <u>Enter only one (1) procedure code per detail line (fields 24A - 24K).</u></b><br/> <u><b>If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.</b></u></p> <p><b>24A. <u>Date(s) of Service:</u></b> Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 04, 2000 = 090400).</p> |
|--|--|

**24B. Place of Service:** Required. Enter the appropriate code as follows:

<u>Code</u> <u>Number</u>	<u>To Be</u> <u>Used For</u>
------------------------------	---------------------------------

11	Office or ambulatory surgery center
32	Nursing facility
31	Skilled Nursing facility

**24D. Procedures, Services or Supplies CPT/HCPCS:** Required. Enter the appropriate procedure code for the service(s) being billed.

**24E. Diagnosis Code:** Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

**24F. \$ Charges:** Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

**24G. Days or Units:** Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

**25. Federal Tax ID Number:** Leave this field blank.

**26. Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your *Remittance and Status Report* under the heading *Patient Account Number*.

**28. Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

**29. Amount Paid:** If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

**30. Balance Due:** Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

**33. Physician's, Supplier's Billing Name, Address, Zip Code And Phone #:** Required. Put the *Name, Address* on all claim forms.

**P.I.N.:** This is the seven-digit number assigned to you by MAA for:

- A. An individual practitioner (solo practice); **or**
- B. An identification number for individuals only when they are part of a group practice (see below).

**Group:** This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number. NOTE: Certain group numbers may require a PIN number, in addition to the group number, in order to identify the performing provider.

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																			
CITY					STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY					STATE																			
ZIP CODE					TELEPHONE (Include Area Code) ( )					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (INCLUDE AREA CODE) ( )																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/>										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____																			
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										17a. I.D. NUMBER OF REFERRING PHYSICIAN										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE																				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)																				22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																			
2. _____																				23. PRIOR AUTHORIZATION NUMBER _____																			
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																																							
1																																							
2																																							
3																																							
4																																							
5																																							
6																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)										33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #																			
SIGNED _____										DATE _____										PIN# _____ GRP# _____																			